

0-02793

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 6 0 8 6 9 9

1. DECEASED NAME (TYPE OR PRINT) Jesse Stephen Bromley			2a. DATE OF DEATH MONTH DAY YEAR March 31, 1986		2b. HOUR 1:30 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR January 27, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory Worker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Kent	13c. CITY OR TOWN Rock Hall	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE THOMAS BROMLEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES WESTEAL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-5200		17. INFORMANT ADDRESS Bennie Dlugoborski, Rt. 2 Box 118	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphoma - abdomen DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3/11/86 to 3/31/86 19 86 that (I) (we) last saw the deceased alive on 3/27/86 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE C. Gottfried Baumann, M.D.		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/1/86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann, M.D.		22e. ADDRESS Medical Building, Chestertown, MD 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 04-02-86	23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Tom Helfenbein Funeral Home, Rock Hall, MD 21661		25a. DATE REC'D. BY REGISTRAR APR 01 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

30% COTTON LURE

00-01556

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) James E. Connolley, Sr.			2a DATE OF DEATH MONTH DAY YEAR March 4, 1986			2b HOUR M	
3 SEX Male		4 RACE Cauc.		5 DATE OF BIRTH March 16, 1921		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10 CITY OR TOWN OF DEATH Galena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Route 213 North		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Utility man		12b KIND OF BUSINESS OR INDUSTRY General Motors	
13a STATE MD				13b COUNTY Kent		13c CITY OR TOWN Galena	
13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS / ZIP CODE Box 73 21635			
14. FATHER'S NAME FIRST MIDDLE LAST Carroll Joseph Connolley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Veronica Hardesty			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 214-28-3045		17 INFORMANT ADDRESS Joseph Connolley	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Cardiovascular atherosclerotic dis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Dr. Michael Bey				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 3/18/86	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Michael Bey				22e ADDRESS Unicorn Medical Ctr./Millington, MD			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 3/7/86		23c NAME OF CEMETERY OR CREMATORY Galena Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Galena Kent MD	
24 FUNERAL DIRECTOR NAME Fellows Funeral Home/Millington, MD				25a DATE REC'D. BY REGISTRAR MAR 24 1986			
				25b REGISTRAR'S SIGNATURE John Davidson			

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 / 0 1

REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George Preston Earle			March 15, 1986			2:28P M			
3. SEX M		4. RACE BLK		5. DATE OF BIRTH MONTH DAY YEAR 06 20 98		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 87 YRS		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. STATE MD		13b. COUNTY QA		13c. CITY OR TOWN Church Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE Rt 1 Box 124 21623	
14. FATHER'S NAME FIRST MIDDLE LAST Robert H. Earle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sullivan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. —		17. INFORMANT Elizabeth Murray		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COPD with Exacerbation DUE TO, OR AS A CONSEQUENCE OF (b) Extensive Pneumonia @ Lung DUE TO, OR AS A CONSEQUENCE OF (c) —								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Constrictive Heart Failure @ CO₂ Narcosis @ Respiratory & metabolic Acidosis									
19. OTHER OPERATION (IF EITHER NOTIFY MEDICAL EXAMINER) WHICH OPERATION WAS PERFORMED Cholecystectomy, Renal Transplantation									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 3/3 , 19 86 , to 3/15 , 19 86 , that (I) (we) last saw the deceased alive on 3/15 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
27b. SIGNATURE KIN KUE WUN		DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/15/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIN KUE WUN				22e. ADDRESS 216 High St, Chestertown, Md. 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/20/86		23c. NAME OF CEMETERY OR CREMATORY Roseville Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Centerville QA MD			
24. FUNERAL DIRECTOR NAME George Dashiell				ADDRESS Easton Md		25a. DATE REC'D. BY REGISTRAR APR 01 1986		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove collision papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		7b. HOUR	
Natalie Neama Embert				3 29 86				2:40AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. IF UNDER 1 YEAR	
Female		white		May 25, 1922		63 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Kent Co. Md.		USA				Kent		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown		Kent & Queen Anne's Hospital Inc.		Adm Asst. Judge (Legal Secretary)					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE			
Kent				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		High St. 21620			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Geo. LeRoy (ROY) Goodman				Anna Harris					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
no		218 16 5091		Geo. B. Rasin, Jr.		Chestertown, Md. 21620			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1: DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Carcinoma of colon with extensive metastases								9 months	
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
3/12/86		Obstruction		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from June 19 85, to March 23, 19 86, that (1) (we) last saw the deceased alive on June 28, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
Susan K. Ross, M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				3/30/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Susan K. Ross				Chestertown, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		Apr. 1, 1986		Chester Cemetery		Chestertown, Md. 21620			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
J. W. Wells				APR 2 1986		J. W. Wells			
NAME				ADDRESS					
J. W. Wells				Chestertown, Md.					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene in order to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



20% COTTON FIBER

00-80080

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 8 0 8 / 0 3

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) ALICE M. NOWAK			2a. DATE OF DEATH MONTH DAY YEAR March 9, 1986			2b. HOUR 10:00 PM			
3 SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 13, 1897		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent Co MD.			
10 CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home Tolchester Ests				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RFD Tolchester 21620	
14. FATHER'S NAME FIRST MIDDLE LAST Nicolas CARPI					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Charlotte Marie BUSSO				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 019 20 0930		17. INFORMANT Rte #2 Box # 445 Virginia Moyer Chestertown, Md. 21620					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL INFARCT DUE TO, OR AS A CONSEQUENCE OF (b) CAROTID ARTERY OCCLUSION DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from AUGUST 19 83 to 9 MARCH 19 86 , that (I) (we) last saw the deceased alive on 8 MARCH 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Harry Paul Ross				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/10/1986	
22d. PHYSICIAN'S NAME (IF OTHER)				22e. ADDRESS Chestertown, Md. 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 3/11/86		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del.			
24. FUNERAL DIRECTOR NAME Wells				ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR MAR 13 1986		25b. REGISTRAR'S SIGNATURE G. Davidson	

MEDICAL CERTIFICATION

29

1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

DHMH - 16 60M 7/B4
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8608704

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen Mae Robinson			2a. DATE OF DEATH MONTH DAY YEAR 3/10/86			2b. HOUR 1:06am					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 1, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD					
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. CITY OR TOWN Q.A.		13c. STREET ADDRESS / ZIP CODE Church Hill 21623		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Jester				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jessie Tarbutton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-28-4925		17. INFORMANT Dudley Jester				ADDRESS Church Hill, MD 21623			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY 887 IMMEDIATE CAUSE (a) Pulmonary arrest DUE TO OR AS A CONSEQUENCE OF (b) Bilateral Pneumonia DUE TO OR AS A CONSEQUENCE OF (c) Congestive Heart Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) ① Impacted Subclavian Fr. of ② Hx ③ ASCVD ④ Cerebral Vascular Dis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 3/9 1986, to 3/10 1986, that (I) (we) lost saw the deceased alive on 3/9 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE KIN KUE WUN				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIN KUE WUN				22e. ADDRESS 216 High St, Chestertown, Md. 21620							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 03-17-86		23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Centreville Q.A. MD					
24. FUNERAL DIRECTOR NAME Tom Helfenben Funeral Home, Church Hill, MD				ADDRESS 21623		25a. DATE REC'D. BY REGISTRAR MAR 24 1986		25b. REGISTRAR'S SIGNATURE G. H. Anderson			

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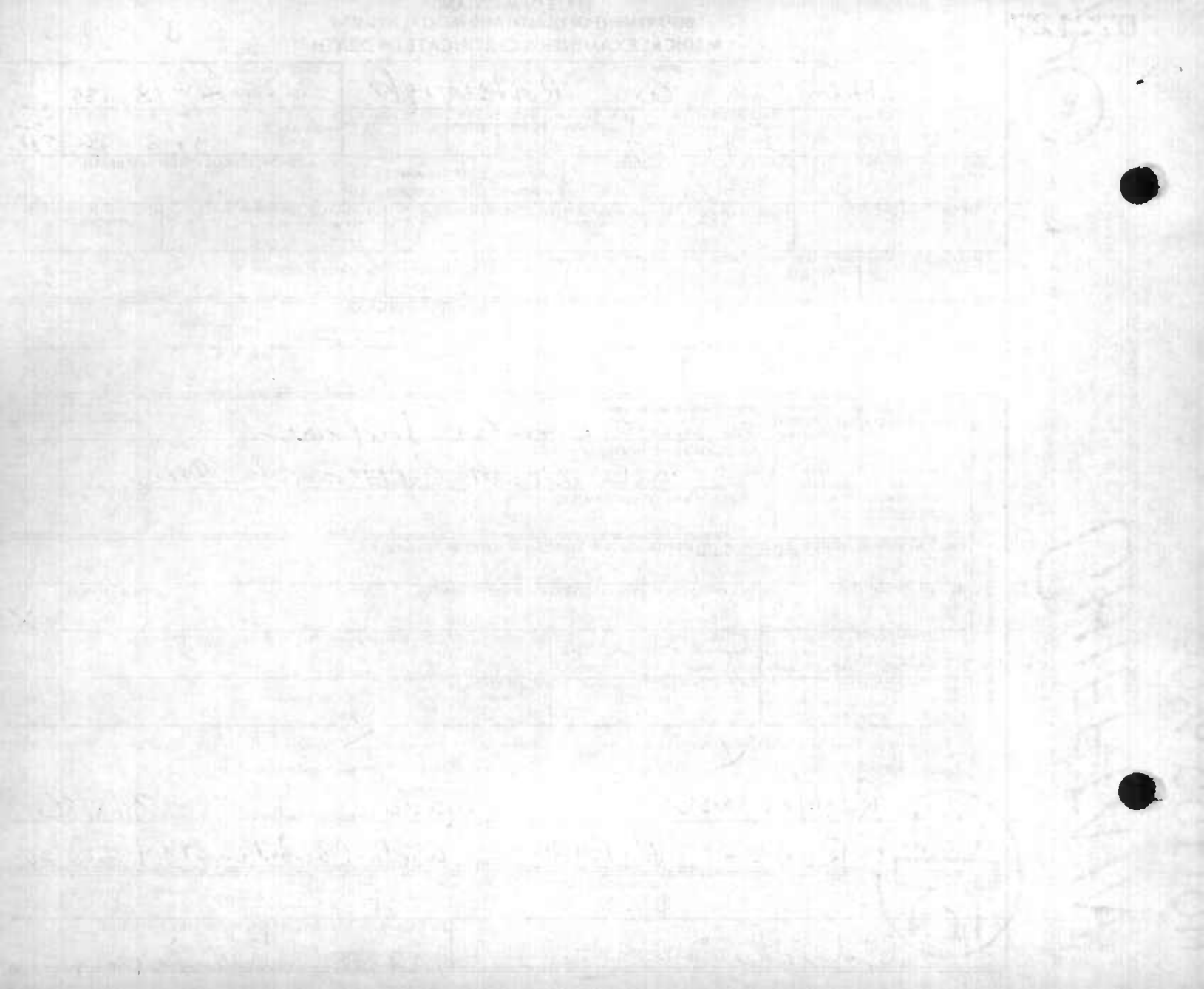
1- FOR
STATE
REGISTRAR ROSBOROUGHSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

08705

1. DECEASED NAME (TYPE OR PRINT) <i>Helen a. Rosborough</i>		2a. DATE KNOWN OF DEATH ESTIMATED <i>3/8</i> 19 <i>86</i>		2b. HOUR <i>12:00</i> M
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR <i>2 19 1907</i>	6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. <i>79</i>	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IOWA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home 108 Birch Run Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 108 Birch Run Road 21620
14. FATHER'S NAME FIRST MIDDLE LAST Jems Sorensen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Anne MELINE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 508 34 1363	17. INFORMANT ADDRESS JoAnne Schleiger Centreville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>arteriosclerotic cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>Robert W. Farr</i>	TITLE (SPECIFY) M.D. <i>Deputy</i> MEDICAL EXAMINER		DATE SIGNED <i>3/8/86</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>ROBERT W. FARR</i>	ADDRESS <i>Kent Co. Chestertown, Md. 21620</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 3/10/86	23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Del.	
24. FUNERAL DIRECTOR NAME <i>John Wells</i> ADDRESS <i>Chestertown, Md.</i>		25a. DATE REC'D. BY REGISTRAR MAR 12 1986	25b. REGISTRAR'S SIGNATURE <i>John Wells</i>	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



071128

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 8 / 0 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPHINE M. SIMPSON			2a. DATE OF DEATH MONTH DAY YEAR Mar. 4, 1986		2b. HOUR 10 M		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR SEPT 18 1914		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 71 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co/ Md/ MD.	
10. CITY OR TOWN OF DEATH Chestertown,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER BLIND		12b. KIND OF BUSINESS OR INDUSTRY SCHOOL	
13a. STATE MARYLAND				13b. COUNTY KENT		13c. CITY OR TOWN MASSEY	
14. FATHER'S NAME FIRST MIDDLE LAST THOMAS J. DUNN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH M. GRADY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-20-7230		17. INFORMANT ADDRESS ANN T. CLEGG - BETTERTON, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) - CVA DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) GI bleed							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Mar 1980 , to Mar 4th 1986 , that (I) (we) lost saw the deceased alive on FEB 27th 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Patrick A. Molony				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/5/86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick A. Molony				22e. ADDRESS Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE MAR 8, 1986		23c. NAME OF CEMETERY OR CREMATORY OLD BOHEMIA CEM		23d. LOCATION CITY OR TOWN COUNTY STATE WATERS - CRYL - MD.	
24. FUNERAL DIRECTOR Robert C. Hutcheson - Middletown, Del.				25a. DATE REC'D. BY REGISTRAR MAR 10 1986		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

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21820-200 AIR TEGG-RETTEN, WIRYLAND

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00-01748

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James Polk Singleton			2a. DATE OF DEATH MONTH DAY YEAR 3 / 28 / 86			2b. HOUR 5:34A M					
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MARCH 17, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.					
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (RET) MATERIALS HND		12b. KIND OF BUSINESS OR INDUSTRY CHEMICAL MANUF.			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY KENT		13c. CITY OR TOWN ROCK HALL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P. O. Box 24 21661			
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW SINGLETON				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE NORA CULLUM							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 30 8059		17. INFORMANT ADDRESS MRS. RACHEL A. SINGLETON SAME AS #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Massive Pulmonary Embolism</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Associated Tuberculosis. Acute</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS, CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Patrick A. Molony M.D.</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 3/28/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICK A. MOLONY M.D.						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 31 MARCH 86		23c. NAME OF CEMETERY OR CREMATORY MT. ZION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE FOUNTAIN GREEN, HARFORD CO., MD.				
24. FUNERAL DIRECTOR NAME ADDRESS MITCHELL FUNERAL HOME PA, HAVRE de GRACE, MD. 21078						25a. DATE REC'D. BY REGISTRAR MAR 31 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (Under by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENAL ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 08 / 08	
1. DECEASED NAME (TYPE OR PRINT) HELEN REBECCA SMITH							2a. DATE KNOWN OF DEATH		3/3/86		2b. HOUR 10 A
3. SEX female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 1/18/1926		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 3/3/83		19 9 15 A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent		MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home Washington Park				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD 21620		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Cann					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aleina Harmon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 217 16 9698		17. INFORMANT ADDRESS Washington Park Wm. "Jake" Smith Chestertown, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Robert W. Farr</u>		TITLE (SPECIFY) M.D. <u>Kent County</u>				MEDICAL EXAMINER		DATE SIGNED 3/3/86			
EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr		ADDRESS Chestertown. Kent Co. Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/6/86		23c. NAME OF CEMETERY OR CREMATORY Jane's Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Rural Chestertown, Md.					
24. FUNERAL DIRECTOR NAME James Perkins - Rock Hall, Md.				25a. DATE REC'D. BY REGISTRAR MAR 7 1986		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>					

1. The first part of the report is a general description of the project and the objectives of the study. It includes a brief history of the project and a statement of the problem to be solved.

2. The second part of the report is a description of the methods used in the study. It includes a description of the experimental apparatus and the procedures used to collect and analyze the data.

3. The third part of the report is a description of the results of the study. It includes a description of the data collected and a discussion of the results in relation to the objectives of the study.

4. The fourth part of the report is a conclusion and a summary of the findings of the study. It includes a statement of the conclusions drawn from the results and a summary of the findings of the study.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 6 0 8 / 0 9

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JOSEPH B. TOWNER (JR.)			2a. DATE OF DEATH MONTH DAY YEAR March 26, 1986		2b. HOUR P 6:30
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov 6, 1922	6. AGE (IN YEARS LAST BIRTHDAY) 63 yrs. YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.		
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home RFD Chestertown, Md.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Chestertown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE RFD Morgnec 21620	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph B. Towner (Sr.)		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henriette Malcolm			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 16 8540	17. INFORMANT ADDRESS Ann N. Towner RFD Morgnec 21610 Chestertown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus, Renal Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-27 19 62 , to 3-11 19 86 , that (I) (we) lost saw the deceased alive on 3-11 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robert W. Farr</i>				22c. DATE SIGNED 3-27-86	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr				22e. ADDRESS Chestertown, Md. 21610	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE March 29, 1986	23c. NAME OF CEMETERY OR CREMATORY Millington Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Millington, Md.		
24. FUNERAL DIRECTOR <i>William Wells</i>			25a. DATE REC'D. BY REGISTRAR APR 01 1986		
25b. REGISTRAR'S SIGNATURE <i>William Wells</i>					

00-55001

REPRODUCTION OF



PROPERTY OF THE

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

3-21-60

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

072126

1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Marcella USILTON

2. DATE OF DEATH MONTH DAY YEAR
March 7, 1986

2b. HOUR A
3:45 M

3. SEX female

4. RACE white

5. DATE OF BIRTH MONTH DAY YEAR
Oct. 1, 1905

6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.
80 YRS.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Q A Co. Md.

7b. CITIZEN OF WHAT COUNTRY?
USA

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH
Kent Co. MD.

10. CITY OR TOWN OF DEATH
Chestertown

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Magnolia Hall Nursing Center

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker

12b. KIND OF BUSINESS OR INDUSTRY

13a. STATE
Maryland

13b. COUNTY
Kent

13c. CITY OR TOWN
Rock Hall

13d. INSIDE CITY LIMITS?
YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE
Rte # 20 RFD 21661

14. FATHER'S NAME FIRST MIDDLE LAST
August Charles Kaufman

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Ernestine Thom

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No

16b. SOCIAL SECURITY NO.
219 14 4552

17. INFORMANT ADDRESS
Ann Leary Rock Hall, Md. 21661

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?
YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED
WHILE ☐ AT WORK NOT WHILE ☐ AT WORK

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-18, 19 83, to 3-6, 19 86, that (I) (we) last
saw the deceased alive on 3-6, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Robert W. Farr DEGREE

22c. DATE SIGNED
3/7/86

22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert W. Farr

22e. ADDRESS
Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial

23b. DATE
3/10/1986

23c. NAME OF CEMETERY OR CREMATORY
Chesterfield Cem.

23d. LOCATION
CITY OR TOWN COUNTY STATE
Centreville, Md.

24. FUNERAL DIRECTOR
NAME ADDRESS
J. Wells Wells Chestertown, Md.

25a. DATE REC'D. BY REGISTRAR
MAR 12 1986

25b. REGISTRAR'S SIGNATURE
John Swinden Boudelle

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

